FILE OF LIFE

Patient Medical Information Inside

Update this form every six months.
Use a pencil, not a pen to fill out this form.

FLUVANNA TRIAD

Personal Information

Full Name: _____

Date of Birth _____/ _____/ _____ Male / Female

Address: _____

City/Town: _____

Zip Code: _____

Home Phone: _____

Mobile Phone: _____

Office Phone: _____

Family Doctor: _____

Blood Type: ____

Emergency Contact

Full Name: _____

Home Phone: _____

Mobile Phone: _____

Relationship: _____

Other: _____

Existing Medical Problems

Please describe below

Heart

_____

_____

Breathing

_____

_____

Stroke / TIA (mini stroke)

_____

_____

High Blood Pressure

_____

_____

Surgeries

_____

_____

Seizure

_____

_____

Diabetes

_____

_____

Psychiatric

_____

_____

Cancer

_____

_____

Other, e.g. mechanical devises, c-pap, etc.

_____

_____

_____

_____

_____

FLUVANNA

TRIAD

Compliments of the
Fluvanna County Sheriff's Office
www.fluvannasheriff.com
(434) 589-8211

Do you have any regular in-home support services? *Please list below*

_____

_____

_____

_____

_____

****Allergies**

_____

_____

_____

Recent Surgery: Y/N **Date:** ___/ ___/ ___ **Describe:** _____

Religion: _____ **Health Proxy:** Y/N **DNR:** Y/N **Advance Directive:** Y/N

Pastor's Name: _____ **Phone:** _____

Medications

Name	Dose	Frequency	What is the medication for?